STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 http://www.state.ar.us/dfa/ebd

Arkansas State Retiree Payroll Deduction Authorization R

(Agency Insurance Rep use only:)

Date Sent: _____

Agency Name: _____ Agency Number: _____

I, _____, hereby authorize you to deduct from my retirement check such amounts as necessary to pay the premiums for my health insurance plan. I further authorize you to pay such amounts to the insurance company providing such personal insurance or to its authorized representative. **This authorization remains in effect until you receive notice from me in writing that it has been changed or revoked.**

The retirement system that I participate in is: **(Check *only* one of the following)**

❒ Public Employees Retirement System (APERS)
❒ Teacher Retirement System (ATRS)
❒ Judicial Retirement System
❒ Arkansas Highway and Transportation Retirement System
❒ Alternative Retirement System (Valic, etc) _____ (Indicate which system)

Please indicate last date of employment _____

My current health insurance carrier is: **(Check one)**

❒ Blue Cross Blue Shield PPO ❒ QualChoice HMO
❒ Health Advantage HMO ❒ QualChoice POS
❒ Health Advantage POS ❒ USAble Life Only

❒ Decline Coverage
- ❒ Other Insurance
- ❒ Medicare Only
- ❒ No Other Coverage
- ❒ Tricare

Please refer to rate sheet to determine amount(s) to record:

Monthly Amount	Self	Self/Spouse	Self/Children	Family
Health Premium				
Basic Life Volume				
Supplemental Life Volume				
Dependent Life Volume				
Total Premium				

If a member is eligible for Medicare and does not have Part B, the plan will pay as though the member does have Part B and the member will have financial responsibility for claims incurred.

If you or your spouse have Medicare Parts A and B, please provide the following information:

Retiree		**Spouse**	
Medicare HIC #	_____	Medicare HIC #	_____
Medicare Part A Effective	_____	Medicare Part A Effective	_____
Medicare Part B Effective	_____	Medicare Part B Effective	_____

Please sign, date and return within 30 days to the address above, attn: Retirement Section

Signature _____ Date _____ SSN _____

(For Office Use Only)

Effective Date: _____ EBD Initials: _____